STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, clinical record reviews, review of facility documentation, review of facility policy and interviews for one of five sampled residents (Resident #20) reviewed for activities of daily living, the facility failed to ensure reasonable accommodations were provided to a resident requiring assistance to get out of bed according to the resident's preferences. The findings include: Resident #20 had diagnoses that included paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs) and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was moderately cognitively impaired and required total assistance of two people with transfers using a mechanical lift. The resident Care Plan dated 6/16/23 identified Resident #20 was paraplegic and dependent with activities of daily living. Interventions directed to provide total assistance with incontinent care. A Customized Wheelchair Positioning Plan dated 6/21/23 identified Resident #21 was to get out of bed to the manual wheelchair at 10:00 AM daily. A social worker progress note dated 11/9/23 identified Resident #20's responsible party expressed concerns that included Resident #20's out of bed schedule. Social services notified the appropriate departments related to the concerns and noted that she would speak with the Director of Nursing as well. An observation and interview with Resident #20 on 5/19/24 at 9:45 AM identified he/she preferred to get out of bed daily following breakfast. Resident #20 often had to wait longer than desired, and staff were aware of his/her preferences. Resident #20 was still in bed and was told that a Hoyer pad (assistive pad to cradle a resident during a transfer with a mechanical lift) was not available and therefore, would have to wait. An interview with NA #4 on 5/19/24 at 10:00 AM identified she provided assistance to Resident #20 with mechanical lift transfers when needed. NA #4 identified Resident #20 preferred to get out of bed by 9:00 AM but that the Hoyer pad required for transfer was in the laundry getting cleaned and would not be available for use until air dried. NA #4 identified there were no alternative transfer pads for use and that staff would be notified by the laundry staff once the pad was ready for use. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #5 on 5/19/24 at 10:06 AM identified she was the assigned aide for Resident #20 that morning. NA #5 identified when there was no laundered Hoyer pads available on the linen cart, staff were required to wait until a clean one was brought up from laundry before being used for resident transfers. NA #5 identified there were no available transfer pads for use as an alternative and that a resident could not get up until a pad was available. An observation and interview with Laundry Staff #1 on 5/19/24 at 10:16 AM identified a large cart filled with clean Hoyer pads (various sizes) in the laundry room. Laundry Staff #1 identified soiled Hoyer pads were cleaned, line dried and placed on linen carts for delivery to the resident units at 6:30 AM and 2: 00 PM daily. If needed sooner, nursing staff can call down or come down to get a pad. An interview with RN #5 on 5/19/24 at 10:50 AM identified she was the assigned Nursing Supervisor that morning and when a Hoyer pad was not available. She was normally notified by staff to address the issue. RN #5 identified she was not notified that there were no available transfer pads. An interview with the DNS on 5/21/24 at 10:51 AM identified she was aware that Resident #20 preferred to get up early right after breakfast. Clean transfer pads were to be brought up to the unit on the linen carts. If a pad was not on the cart staff were expected to call down or go down to laundry to get a transfer pad. Further there were plenty of transfer pads so availability should never be an issue. A subsequent observation on 5/19/24 at 11:00 AM identified NA #5 roll the mechanical transfer and Hoyer pad into Resident #20's room at 11:00 AM. Resident #20 was observed up in h/her chair a short time later. A review of the Resident [NAME] of Rights directed that a resident had the right to reasonable accommodation of individual needs, preferences, and choices about all aspects of life that are significant to that resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility documentation review, and interviews for one of five sampled residents (Resident #124) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure a referral was made to the state mental health authority for a resident who was transferred from a nursing home and had a previous negative level I PASRR but had a diagnosis of a serious mental health condition was reassessed upon transfer from one nursing home to another. The findings include: Resident #124 was admitted to the facility on [DATE] with diagnoses that included adult personality and behavior disorder, schizophrenia, intellectual disabilities, anxiety, depression, psychoactive substance abuse. SW #1's progress note dated 10/13/23 at 9:14 AM identified Resident #124 was admitted from another nursing home and had a past medical history of opioid abuse, schizophrenia, anxiety, adult personality disorder, behaviors, and depressed mood. The note further identified the resident was oriented, able to make his/her needs known, and was conserved. Additionally, the note identified SW #1 would continue to provide 1:1 emotional support as needed for ongoing care needs. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #124 had intact cognition, required extensive assistance with hygiene, required limited assistance with transfers and ambulation. The assessment further identified that Resident #124 had not had a level II PASRR evaluation and determined to have a serious mental illness and/or mental retardation or a related condition. Resident #124's care plan dated 10/30/23 identified the risk for fluctuation in mood and behavior related to schizophrenia, adult personality disorder, anxiety, and depression. Care plan interventions directed to observe for mood changes, provide consistent daily routine, one to one visits with the social worker as needed, and encourage participation in activities program. Review of the level 1 PASRR screening dated 10/10/19 identified Resident #124 had a negative level 1 and did not require a level II PASRR screening at that time. The screening identified that if changes occurred a new screen must be submitted (the purpose of the Level I screen is to identify individuals intended for evaluation through the PASRR Level II process, to identify those individuals with known or suspected mental illness and/or intellectual disabilities). Interview with SW #1 (Director of Social Work) on 5/21/24 at 9:50 AM identified she was responsible for submitting PASRR screening requests to the authoritative entity responsible for conducting the PASRR assessments. She identified Resident #124 did not have a qualifying diagnosis at the time the level I was completed when the resident was at the previous facility. SW #1 further identified Resident #124 had diagnoses of schizophrenia, intellectual disabilities, personality, and behavioral disorders when admitted to the facility that would require a new PASSR screening. She further identified that she should have reviewed the diagnoses on admission and submitted a request for a new PASRR screening related to Resident #124's serious mental health condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to the interview with SW #1, a request for a new PASRR screening was submitted to the authoritative entity responsible for conducting the PASRR screenings. Although requested, a policy addressing the PASRR screening was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, review of facility documentation, review of facility policy and interviews for one of five sampled residents (Resident #20) reviewed for activities of daily living, the facility failed to ensure the comprehensive care plan was revised to include a resident preference for getting out of bed. The findings include: Resident #20 had diagnoses that included paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs) and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was moderately cognitively impaired and required total assistance of two people with transfers using a mechanical lift. The Resident Care Plan dated 6/16/23 identified Resident #20 as paraplegic and dependent with activities of daily living. Interventions directed to provide total assistance with incontinent care. A Customized Wheelchair Positioning Plan dated 6/21/23 identified Resident #21 was to get out of bed to the manual wheelchair at 10:00 AM daily. A social worker progress note dated 11/9/23 identified the responsible party expressed concerns that included Resident #20's out of bed schedule. Social services notified the appropriate departments related to the concerns and would speak with the Director of Nursing as well. An observation and interview with Resident #20 on 5/19/24 at 9:45 AM identified he/she preferred to get out of bed daily following breakfast. Resident #20 often had to wait longer than desired, and staff were aware of h/her preferences. Resident #20 was still in bed and was told that a Hoyer pad (assistive pad to cradle a resident during a transfer with a mechanical lift) was not available and therefore, would have to wait. An interview with Nurse Aide, NA #4 on 5/19/24 at 10:00 AM identified she provided assistance to Resident #20 with mechanical lift transfers when needed. NA #4 identified Resident #20 preferred to get out of bed by 9:00 AM but that the Hoyer pad required for transfer was in the laundry getting cleaned and would not be available for use until air dried. NA #4 identified there were no alternative transfer pads for use and that staff were to be notified by laundry once the pad was ready for use. A subsequent observation on 5/19/24 at 11:00 AM identified NA #5 roll the mechanical transfer and Hoyer pad into Resident #20's room at 11:00 AM. Resident #20 was observed up in his/her chair a short time later. An interview with the DNS on 05/21/24 at 10:51 AM identified she was aware that Resident #20 preferred to get up early right after breakfast. The staff were also aware to get Resident #20 up just after breakfast and were expected to do so according to preference. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #1 (Lead Nurse Aide) on 5/22/24 at 12:12 PM identified Resident #20 preferred to get out of bed daily just after breakfast. An Interview with Person #3 on 5/23/24 at 12:18 PM identified he/she was the responsible party for Resident #20. Person #3 identified meetings were held to discuss Resident #20's out of bed schedule. Person #3 agreed that Resident #20 could get out of bed by 9:00 AM. However, Resident #20 reported staff don't always comply. An interview with Corporate Nurse #1 on 5/23/24 at 11:36 AM identified a Resident's preference should be included as part of the comprehensive care plan and revised with changes. A review of the facility policy for Comprehensive Care Plans directed that the Interdisciplinary Team was responsible to develop a comprehensive care plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical nursing, and psychosocial needs. The Care Plan is evaluated and revised as needed and quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, review of facility documentation, review of facility policy and interviews for one of three sampled residents (Resident #14) reviewed for change of condition, the facility failed to complete a nursing assessment following a change of condition. The findings include: Resident #14 had diagnoses that included chronic obstructive pulmonary disease (COPD), morbid obesity and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 and required extensive two person assist with bed mobility and transfers. The Resident Care Plan (RCP) dated 3/7/24 identified medication was prescribed to manage heart disease. Interventions directed to follow the protocol for sudden chest pain and complete a cardiac assessment per protocol. A hospital discharge summary dated 3/13/24 identified Resident #14 was transferred to the emergency roiagnom on [DATE] following a complaint of chest pain. A review of the clinical record did not include a documented change of condition or nursing assessment following the resident's complaint of chest pain. An interview with the Director of Nursing (DNS) on 5/22/24 at 12:06 PM identified she would expect a nursing assessment to be completed for any resident experiencing a change of condition. An interview with RN #1 on 12/21/24 identified she was the assigned Nursing Supervisor on 3/11/24 during the 7:00 AM to 3:00 PM shift when she was notified Resident #14 was reporting chest pain. RN #1 went to the unit and was informed an order was obtained to transfer Resident #14 to the emergency department for further evaluation. RN #1 identified she did not complete a nursing assessment for Resident #14 prior to the hospital transfer but was aware another registered nurse, RN #2 had assisted the charge nurse. An interview with RN #2 on 5/22/24 at 12:23 PM identified she was unable to recall what, if any assistance she provided to the charge nurse on 3/11/24 but would have documented the assessment in the clinical record if completed. Although requested, a policy for completing an RN assessment following a change of condition was not provided. Although requested, a policy for chest pain protocol and cardiac assessment was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of the clinical record, review of facility documentation, review of facility policy and interviews for two of three sampled residents (Resident #124 and #159) reviewed for range of motion and splint usage, the facility failed to ensure a resident who required splints had an order in place and failed to ensure the splints were applied per occupational therapy recommendations and failed to provide treatment as ordered by the physician. The finding includes: 1. Resident #124 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, cardiovascular accident (CVA) with left sided weakness, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #124 had intact cognition, had a functional limitation in range of motion of the upper and lower extremity. Resident #124's care plan dated 4/5/2024 identified the risk for pressure ulcer development with interventions that included observe skin integrity with application and removal of splint, treat skin folds per MD, be aware of efficacy, evaluate for signs/symptoms of healing and infection, inspect skin for signs and symptoms of redness or breakdown daily. Interview with resident #124 on 5/21/24 at 2:57 PM identified he/she did not have his/her splint applied to the left hand. Resident #124 noted that an ace bandage was supposed to be in place on his/her left hand at night for swelling but noted that it had not been applied in quite some time. Observation at the time of the interview, noted a grey and blue colored splint in the resident's room, and the nurse aide care card was affixed to the back of the resident's room door. Observation on 5/21/2024 at 3:15 PM noted the nurses' station contained a Kardex (a filing system that is used as a quick reference for nurses. It is a desktop file system that gives a brief overview of each patient) binder which contained splint training documentation dated 2/14/24. Review of the documentation identified Resident #124's splint was to be applied to the left hand in the AM with care and removed on last rounds on the 7-3pm shift. The documentation contained a picture of the splint, in-service attendance records showing that five staff were provided with the training. Review of the nurse aide care card in the resident's room did not have a notation that that the resident utilized a splint. Observation on 5/22/2024 at 9:40 AM identified Resident #124's left hand was unadorned. The resident did not have the splint in place. The physician's orders for May/2024 did not consist of an order for a left-hand splint. Review of the medication administration record and the treatment administration records failed to identify orders directing the use of a left-hand splint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Rehabilitation Director (RD) on 5/22/24 at 10:00 AM identified Resident #124 was treated by occupational therapy from October/2023 through February/2024 for contracture management. The RD further identified the process in place for the ordering of splints includes the therapist entering the order into the electronic system, and a paper copy of the order is given to the physician/provider to sign. Additionally, the RD identified Resident #124 would be evaluated to identify improvements and/or deterioration in function. Observation on 5/23/24 at 10:36 AM identified Resident #124 with a splint applied to the left hand. Interview and chart review with OT #1 on 5/23/2024 at 10:41 AM identified he had evaluated Resident #124 earlier that morning and noted the resident was similar in strength from when he/she was discharged from therapy in February/2024. Additionally, OT #1 identified the splint was in place and Resident #124 identified he/she felt the left wrist was more contracted than it was previously, and the nursing staff was not following through with the splint application schedule. Further, OT #1 noted Resident #124's hand was resisting the splint more than it had in the past. After reviewing the record, OT #1 noted Resident #124 went to the hospital in April and when he/she returned the orders were not reinstated. He further noted that the resident was provided therapy upon readmission to the facility and during the time the resident was receiving therapy, the splint was applied by therapy staff. In addition, OT #1 noted that as a result of the evaluation completed that morning, the resident would be seen for therapy three to four times per week for function and range of motion. Interview with APRN #1 at 5/23/24 at 11:01 AM identified that the process for addressing therapy orders is as follows: therapy writes what is needed in a communication book on the unit, she then reviews and writes an order in the paper chart. She further noted that she does not enter any orders into the electronic system. In addition, APRN #1 noted Resident #124 complained that the nursing staff were not applying the ace wrap for compression and noted that she reordered the ace wrap but was unaware of the need to reorder the splint. Interview with LPN #5 on 5/23/24 at 11:10 AM identified that the order for the splint was discontinued on 4/4/24 (resident's readmission to the facility). LPN #5 further noted that the order directed to apply the splint in the AM and remove in the PM and noted the resident was able to self-remove the splint. Interview on 5/23/24 at 11:22 AM with CNA #5 identified she was assigned to care for Resident #124 and noted that to know what to do for the resident she refers to the nurse aide care card located on the back of the door and looks at what is noted in the electronic system. She further noted that the care card did not specify the use of a splint and neither did the electronic system. Interview with the Infection Preventionist on 5/23/24 at 11:31 identified that when residents have a hospital stay, the orders are discontinued and upon readmission, the admitting nurse is responsible for reinstating relevant orders. She further noted that this is what occurred with Resident #124's splint orders and that when the resident was readmitted , the order for the splint should have been reinstated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the RD on 5/23/24 at 11:52 AM identified Resident #124 was evaluated by OT on 4/5/24 (when resident returned from the hospital) and treated until 4/26/24. He further noted that the therapist would have been responsible for ordering the splint and for providing education to the staff concerning the application of the splint. Interview with the RD on 5/23/2024 at 2:29 PM identified the OT wrote the order for the splint on 4/26/2024 and the order was signed by the APRN, but the order was not entered into the electronic system. Review of the Splints/orthotics/prosthetics policy dated April 2015 identified the residents will receive splint/orthotic/prosthetic devices as deemed appropriate by the physician and rehabilitation services. If the resident refuses to wear the device, notify the rehab department, physician, and responsible party. The facility failed to ensure that Resident #124's splint was applied on a consistent basis and that the resident did not experience a decline in range of motion. 2. Resident #159's diagnoses included aphasia, hemiplegia, contracture of muscle to left hand and left forearm, and gastrostomy. The quarterly MDS assessment dated [DATE] identified Resident #159 had severely impaired cognition, was dependent for toileting hygiene, dressing, personal hygiene, transfers, was non-ambulatory and had impairment with range of motion to the upper and lower extremity on one side. The care plan dated 4/8/24 identified Resident #159 had limited range of motion to the left upper extremity with interventions that included staff to assist with ADL's (activities of daily living) and therapy referral as needed. The care plan further identified the risk for pressure ulcers related to dependent mobility with an intervention that included rolled gauze to left inner hand for prevention and protection. The physician's order dated 4/21/24 directed to apply rolled gauze followed by inter dry to left inner hand three times per week Tuesday, Thursday, and Saturday on the 7:00 AM to 3:00 PM shift. Observation on 5/19/24 at 1:26 PM identified Resident #159 lying in bed with the left hand positioned across his/her chest without the benefit of the rolled gauze to the left inner hand, nor was it observed on the bed. Observation on 5/21/24 at 10:15 AM identified Resident #159 lying in bed slightly turned to the right with the left hand positioned across his/her abdomen without the benefit of the rolled gauze to the left hand nor was it observed on the bed. Observation on 5/21/24 at 2:35 PM with the Charge Nurse (LPN #8) identified Resident #159 lying in bed on the right side facing the window with left hand across his/her chest without the benefit of the rolled gauze to the left hand nor was it observed on the bed. Review of the Treatment Administration Record (TAR) with LPN #8 on 5/21/24 at 2:45 PM identified the physician's order which directed to apply rolled gauze followed by inter dry to left inner hand was signed off for 5/21/24 by LPN #8 at 12:50 PM as having been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #8 on 5/21/24 at 2:45 PM identified she had not completed the treatment. LPN #8 identified that if the treatment order was signed off it indicated that it was completed. LPN #8 further indicated that she had an admission and got distracted. LPN #8 added that if she had not completed the treatment, she should not have signed off that it was completed on the TAR but should have reported to the supervisor and the oncoming shift that it was not completed. Following the observation and interview with LPN #8, she applied rolled gauze followed by inter dry to the left inner hand of Resident #159. Interview with the RD on 5/22/24 at 12:37 PM identified Resident #159 utilized the rolled gauze and inter dry to prevent further contraction of the hand and to maintain skin integrity. The RD further noted Resident #159 was currently working with the occupational therapist regarding the use of a splinting device. Interview with the DNS on 5/22/24 at 10:04 AM identified that when nurses sign the TAR, it indicates that the treatment or task was completed. The DNS further identified if the nurses become busy with other tasks, they should ask for help. Review of the Treatment policy identified that once treatments are ordered that they are to be carried out as prescribed and treatments should be charted on the treatment sheet by indicating initial in the appropriate slot. The policy further identified that if treatment was omitted, the initial should be circled and a reason for the omission including the date, the time to be documented as well as the physician should be notified of the omission. 47900

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, review of facility documentation, review of facility policy and interviews for one of four sampled residents (Resident #88) reviewed for nutrition, the facility failed to obtain weights/re-weights for a resident with significant weight discrepancy. The findings include: Resident #88 had diagnoses that included type II diabetes, protein-calorie nutrition, and dysphasia. The quarterly MDS assessment dated [DATE] identified Resident #88 was cognitively intact and required supervision with bed mobility, eating and was dependent with transfers. The resident care plan dated 8/29/23 identified Resident #88 was at nutritional risk related to a recent hospitalization . Interventions directed to provide a regular pureed diet, supplement as ordered, provide assist of one for self-feeding and weigh as ordered. Physician readmission orders dated 11/22/23 directed weekly weights every Wednesday during the 7:00 AM to 3:00 PM shift through 12/20/23. Weight record dated 11/26/23 identified a documented weight of 153lbs. A nutritional quarterly progress note dated 11/29/23 identified Resident #88 was receiving a regular pureed diet with adaptive equipment to aid in self-feeding and supplementation. Intake was 76-100% and the current weight was 153lbs. Recommendations included discontinuing protein supplementation due to a previously reported skin integrity issue that was reported in error. The weight record dated 12/3/23 through 12/20/23 identified no weekly weights on three successive weeks for Resident #88. Further, the weight record dated 1/14/24 identified a documented weight of 134.5lbs with no available re-weight. A Nutritional progress note dated 1/19/24 identified Resident #88's current weight was 134.5 reflecting a 21lb. (13%) weight loss of unknown etiology. Resident #88 was receiving ground intake with total supervision and adaptive equipment Intake was between 76-100%, accepting meals and supplements. Recommendations included weekly weights for 4 weeks and monitor. A review of the facility Bulletin Board, an internal communication system to the Administrator, Director of Nursing, Assistant Director of Nursing, licensed staff, and Nurse Aide staff identified daily from 1/16/24 through 1/19/24 and 1/23/24, a re-weight was requested from the dietitian which was not responded to. The weight record dated 1/23/24 identified a recorded weight and verified re-weight of 126lbs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Dietitian on 5/23/24 at 10:31 AM identified nursing staff was responsible for ensuring the completion of weights in accordance with physician orders and report weight changes once a discrepancy has been verified. Once the weight discrepancy was identified, the Dietitian requested a re-weigh from staff utilizing the internal communication system on seven different occasions between 1/16/24 and 1/23/24 which were not responded to. The Dietitian indicated she had already made several amendments to Resident #88's diet to address the potential weight loss immediately beginning 1/16/24. An interview with the Regional Corporate Nurse on 5/23/24 at 11:19 AM identified weights to be reported to the dietitian once a discrepancy has been verified. The Regional Corporate Nurse identified re-weighs should have been obtained for Resident #88 as requested. A review of the facility policy for Weights directed a weight loss/gain of 5lbs. or more for a resident weighing 100lbs. or more requires a re-weight for verification. If a significant weight loss/gain is identified (>5lbs. in 30 days, the IDT, dietitian, and family are notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, review of the clinical record, review of facility documentation, review of facility policy and interviews for one of four sampled residents (Resident #82) reviewed for respiratory care, the facility failed to ensure respiratory equipment was maintained and respiratory services were provided in accordance with physician orders. The findings include: 1. Resident #82 had diagnoses that included Chronic Obstructive Pulmonary disease (COPD) and myocardial Infarction. The resident care plan dated 4/3/24 identified Resident #82 had an activity in daily living (ADL) deficit. Interventions directed to assess functional level, provide assistance with ADLs, and assess interests. The admission MDS assessment dated [DATE] identified Resident #82 was cognitively intact and independent with activities of daily living. Physician orders dated 4/17/24 directed to change oxygen tubing weekly on the 11:00 PM - 7:00 AM shift beginning 4/21/24. An observation with LPN #1 on 5/19/24 at 11:57 AM identified the oxygen delivery system was on and the oxygen tubing was dated 4/23/24. An interview with LPN #1 on 5/19/24 at 11:57 AM identified she was unsure who was responsible for changing the oxygen tubing but that it should be changed weekly and dated. LPN #1 further identified the oxygen tubing should have been dated within the past seven days. An interview with the DNS on 5/21/24 at 11:03 AM identified oxygen tubing should be changed weekly in accordance with physician orders on either the 3:00 PM to 11:00 PM shift or 11:00 PM to 7:00 AM shift. The DNS further noted she would expect the tubing to have been changed and dated within the past 7 days. A review of the facility policy for Oxygen Administration by Nasal Cannula dated 11/2020 directed to replace and date the cannula and tubing weekly or when visibly soiled. 2. Resident #82 had diagnoses that included Chronic Obstructive Pulmonary disease (COPD) and myocardial Infarction. The resident care plan dated 4/3/24 identified Resident #82 had an activity in daily living (ADL) deficit. Interventions directed to assess functional level, provide assistance with ADLs, and assess interests. The admission MDS assessment dated [DATE] identified Resident #82 was cognitively intact and independent with activities of daily living. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 4/17/24 directed to change oxygen tubing weekly on the 11:00 PM - 7:00 AM shift beginning 4/21/24. An observation with Licensed Practical Nurse, LPN #1 on 5/19/24 at 11:57 AM identified the oxygen delivery system was shut off at Resident #82's request. A subsequent observation with LPN #4 on 5/22/24 at 12:50 PM identified the oxygen delivery system on and set at 4l/min with the tubing located beside Resident #82. An interview with Resident #82 on 5/22/24 at 12:50 PM identified he/she used oxygen intermittently and that it helped with respiratory symptoms. Resident #82 further identified that when needed he/she turned the unit on, and with the liter flow already set, self-applied the cannula. A review of the clinical record identified Resident #82 did not have physician's orders for the use of oxygen. An interview and clinical record review with APRN #1 on 5/22/24 at 1:00 PM identified Resident #82 was weaned off oxygen prior to admission to the facility. APRN #1 identified Resident #82 should not have received oxygen without a physician's order. APRN #1 further identified that although Resident #82 showed no symptoms, placing a resident with COPD on oxygen who did not need it places the resident at risk for developing hypercarbia (increased buildup of carbon dioxide in the blood). An interview with NA #1 on 5/22/24 at 1:10 PM identified he had observed Resident #82 self-administer oxygen at times when short of breath and that it seemed to help with symptoms. An interview with the Director of Nursing on 5/22/24 at 1:32 PM identified Resident #82 should not have had orders in place for oxygen tubing changes if there was no order for oxygen and Resident #82 should not have had physician orders in place for oxygen if not needed. A review of the facility policy for Oxygen Administration by Nasal Cannula dated 11/2020 directed to deliver low flow oxygen and equipment in accordance with physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47489 Based on observations, review of facility policy and interviews for 2 of 4 medication carts reviewed, the facility failed to ensure expired medications were removed from the medication carts and failed to ensure a multiuse vial of insulin was dated when opened. The findings included: Observation with LPN #5 on 05/21/24 at 9:19 AM of the 4th floor medication cart #2 identified the following: Resident 160 had five blister packs of expired medication, which were as follows: * Levetiracetam 500 mg, with an expiration date of 3/16/2024. * Levetiracetam 500 mg tablets (30 tablets remaining in the blister pack) with directions to administer one tablet by mouth twice per day, with an expiration date of 5/1/2024. * Eliquis tab 5mg tablets (29 tablets remaining in the blister pack) with directions to administer one tablet by mouth twice per day with an expiration date of 3/15/2024. * 5mg tablets (30 tablets remaining in the blister pack) with directions to administer one tablet by mouth twice per day with an expiration date of 2/19/24 * Clopidogrel 75 mg tablets (30 tablets remaining in the blister pack) with directions to administer one tablet by mouth once a day with an expiration date of 3/14/2024. Additionally, the medication cart also contained a blister pack of Trazodone 50mg tables with 30 tablets remaining in the pack with an expiration of 3/28/24 for Resident #116. Interview with LPN #5 on 5/21/24 at 9:19 AM identified she goes through the cart once monthly and is usually on the 4th floor on either cart #1 or #2. LPN #5 was not sure who was responsible for checking the medication cart but indicated the nurse who is on duty when the medications come in is responsible to put the incoming medication away and rotate the stock. Observation of the 4th floor medication cart #1 on 5/21/24 at 9:30 with LPN #5 identified a vial of Glargine insulin 100units/ml that did not contain the date it was opened and had an expiration date of 4/2025. Further observations identified the following: * Olanzapine 2.5mg tablets with directions to administered one tablet by mouth at hour of sleep with an expiration date of 8/28/22. The blister pack contained 26 tablets and was noted to be for Resident #74. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* The following was noted for Resident #88: Darifenacin 7.5 mg tablets (9 tablets remained in the blister pack) with directions to administer one tablet by mouth everyday with an expiration date of 2/9/2024, Glipizide 10 mg tablets (16 tablets remained in the blister pack) with directions to administer one tablet by mouth twice per day with a noted expiration date of 11/30/2023, Jardiance10mg tablets (30 tablets remained in the blister pack) with directions to administer one tablet by mouth daily with an expiration date of 4/4/2024, and Mirtazapine 7.5mg tablets (15 tablets remained in the blister pack) with directions to administer one tablet at bedtime with an expiration date of 4/9/2024 Interview with RN #1 on 5/21/24 at 9:34 AM identified that all nurses were responsible for rotating stock or checking expiration dates. Interview with the ADNS on 05/21/24 at 9:50 AM identified the night shift nurse is responsible to rotate stock and go through the carts for medication expiration dates. Interview with the Pharmacy Manager on 5/23/2024 at 12:11 PM identified the facility is responsible for rotating stock and blister packs based on when they were received and the expiration date. He further identified the expired medications should have been returned to the pharmacy. Interview with the Pharmacist Consultant on 5/23/24 at 12:55 PM identified the consultants visit the facility once monthly and go through the carts and medication rooms. The Pharmacy Consultant was responsible for checking expiration dates on over-the-counter medications, insulins, PPD vials. The Pharmacist Consultant further identified they do not check the blister packs that are resident specific. Review of the Medication Storage Policy identified Medications must be stored in accordance with manufacturer's specifications and in compliance with State and Federal requirements and accepted professional standards of practice. Additionally, the policy identified that prior to and after opening, all medications shall expire on the date specified by the manufacturer on the product label. Review of the Medication Storage Room/Medication Cart Policy identified Licensed personal will be responsible to check expiration dates on ordered medications, house stock medications, and supplies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of facility documentation, review of facility policy, and interviews for four of four sampled residents (Residents #13, #55, #144, and Resident #156) reviewed for infection surveillance, the facility failed to appropriately cohort residents with a known Multidrug Resistant Organism (MDRO) colonization, the facility failed to review the infection prevention control program policies and procedures at least annually, the facility failed to ensure environmental rounds were conducted by the department heads on a quarterly basis, and failed to follow the policy and procedural measures developed by the facility to prevent the growth of Legionella and other water borne pathogens in the building water system. The findings include: 1. Review of the facility's MDRO log and Bed Board with the Infection Preventionist (IP) Nurse (LPN #6) and the Regional Nurse (RN #7) on 5/21/24 at 11:37 AM identified Resident #55 and Resident # 144 were roommates with each resident having different colonized MDRO's. Resident #55 colonization history included extended-spectrum beta-lactamases (ESBL) while Resident #144 colonization history included Methicillin- Resistant staphylococcus aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), and ESBL. The MDRO log and Bed Board further identified that Resident #13 had no history of an MDRO and shared room with Resident #156 who had a known history of a colonized MDRO of CRE. Resident #55's diagnoses included history of urinary tract infection, obstructive and reflux uropathy, anxiety, and chronic kidney disease. The annual MDS assessment dated [DATE] identified Resident #55 had intact cognition, required limited assistance with toilet use, bed mobility, personal hygiene, and non-ambulatory. The assessment further identified that Resident #55 had an indwelling catheter and was frequently incontinent of bowel. The care plan dated 6/20/23 identified Resident #55 had a history of ESBL and was placed on enhanced barrier precautions due to a foley with interventions that included gown and gloves to be worn for all high resident contact. Review of the hospital clinical records dated 6/4/23 identified Resident #55 had a positive urine culture dated 9/5/21 that indicated Klebsiella Pneumoniae, ESBL producer. Resident #144's diagnoses included dementia, resistance to multiple antibiotics, type 2 diabetes mellitus, and neuromuscular dysfunction of the bladder. The quarterly MDS assessment dated [DATE] identified Resident #144 had moderately impaired cognition, required total care with toileting hygiene, transfers, and non-ambulatory. The assessment further identified Resident #144 had an indwelling catheter and frequently incontinent bowel. The hospital Interfacility Transfer Summary dated 3/22/24 identified Resident #144 had VRE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical records identified Resident #144 had a urine culture dated 6/14/23 that identified the resident to have a growth of Klebsiella pneumonia ESBL. The records further identified a blood culture result dated 1/3/24 that identified a growth of the organism E. coli ESBL producer and MRSA. Review of the facility's census report identified that Resident #55 and Resident #144 became roommates on 6/4/2023. Interview with LPN #6 and RN #7 on 5/21/24 at 11:37 AM identified that the MDRO log and the Bed Board is completed and updated both by the admission personnel and the IP nurse on admission and with any newly identified MDRO results. LPN #6 added had only started working in the role as an IP for only a year and a half now at the facility and kept the current MDRO logs and updated it as needed. RN #7 identified that residents with an MDRO would be paired with a resident with the same MDRO and if not possible would be cohorted with a resident that had a low risk for transmission. Interview with the Director of Admission (LPN #7) on 5/22/24 at 3:15 PM identified that the MDRO log and the bed board are utilized for room placement of residents. LPN #7 identified that it was an oversight by them in placing Resident #55 and #144 together in the same room. She further identified that they became roommates on 6/4/23. Subsequent to surveyor's inquiry Resident #55's room was changed on 5/22/24. Review of the Precautions to Prevent Transmission of Infectious Agent policy identified for room placement that residents with colonized or infected with an MDRO should not be placed with roommates who are severely immunocompromised or have an indwelling lines or open wounds. Resident #13's diagnoses included type 2 diabetes mellitus, schizoaffective disorder, and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #13 had moderately impaired cognition, required moderate assistance with toileting hygiene, personal hygiene, and ambulation utilizing a walker. The assessment further identified Resident #13 as occasionally incontinent of bowel and bladder. The care plan dated 3/28/24 identified Resident #13 was placed on Enhanced Barrier precaution due to having a history of CRE with interventions that included gown and gloves to be worn for all high contact care. Review of Resident #13 hospital clinical records identified wound culture result dated 5/12/2019 that was positive for Carbapenem Resistant Organism (CRE). Resident #156's admitting diagnoses included joint replacement surgery, left artificial knee joint, muscle weakness, and hyperlipidemia. The quarterly MDS assessment dated [DATE] identified Resident #156 had intact cognition, independent with toileting hygiene, personal hygiene, transfers and was ambulatory. The assessment further identified Resident #156 was always continent of bowel and bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #156 clinical records failed to identify that the resident had an history of an MDRO. Interview with LPN #6 on 5/23/24 at 12:30 PM identified that Resident #156 did not have a history of a MDRO and will have to review the MDRO log to ensure that the residents are cohort appropriately. Review of the facility's census report identified that Resident #13 and Resident #156 became roommates on 4/2/2024. Review of the MDRO Infection and Colonization policy identified that residents with similar MDRO infections can be cohorted when possible. The policy further identified that residents who have CRE should be placed in a single room or cohorted with a roommate with CRE. The Precautions to Prevent Transmission of Infectious Agent policy identified for room placement that residents with colonized or infected with an MDRO should not be placed with roommates who are severely immunocompromised or have an indwelling lines or open wounds. 2. Review of the facility's Infection Control Program Policies and Procedure manual for the past three years (2022, 2023, and 2024) on 5/21/24 at 11:37 AM failed to identified that the policies and procedures manual was reviewed in the year 2022. Interview with LPN #6 and RN #7 on 5/22/24 at 1:30 PM identified that they were unable to locate documentation that the policy and procedures manual was reviewed in the year 2022. LPN #6 indicated that she was not working as the IP nurse during the time it was due to be completed. They identified that it was the responsibility of the then IP nurse to ensure that the infection control policies and procedures were reviewed and signed off annually. Review of the Infection Prevention Program policy identified that infection control policies would be reviewed annually and signed off by the Medical Board. 3. The facility's infection control environmental round documentation for the years 2022, 2023 and 2023 on 5/22/24 at 1:30 PM with LPN #6 and RN #7 identified that quarterly environmental rounds were not completed by the nursing department in the month of January of 2022 and 2023, July of 2022, October 2023, and were not completed by the laundry and housekeeping department for April 2023. Interview with LPN #6 and RN #7 on 5/22/24 at 1:30 PM identified they were unable to locate the environmental rounds survey worksheets for the months of January 2022 and 2023, July 2022, October of 2023, and April of 2023. LPN #6 identified that she was responsible for providing the work sheet to the different department heads which included laundry, housekeeping, dietary and nursing, but it was their responsibility to complete their environmental rounds. LPN #6 added that she was responsible to ensure that the nursing environmental rounds were completed and had only started working in the role as an IP for only a year and a half at the facility. Interview with the DNS on 5/22/24 at 9:53 AM identified that she had started to have the IP nurse complete the environmental rounds monthly for 2023 and was unable to state what had happened to the environmental rounds for 2022. The DNS added that the rounds are completed by an interdisciplinary team with each department responsible for completing their rounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 5/22/24 at 10:13 AM identified he was responsible for reviewing the rounds after they are completed by the various departments. The administrator added that he would be part of the rounds at times with the housekeeping, dietary, and maintenance department but failed to identify why the rounds were incomplete. Review of the Environmental Rounds policy identified that the infection preventionist and department heads on a regular basis but at least quarterly. The policy further identified that the department heads would submit the completed environmental rounds form to the IP, the Administrator would review the rounds and the environmental survey worksheets would be retained for review. 4. The Facility Water Management Plan Policy identified that the facility would maintain a monthly log that included water flushing of the identified low flow areas, eyewash to be run for three minutes weekly, and annually water sampling testing. The facility was unable to produce completed logs for the year 2022 that indicated that the identified low flow areas were flushed. The facility also was unable to produce completed logs for the year and for the years 2022, 2023, and 2024 when the eyewash was run for three minutes weekly as per the facility Water Management Plan. Interview with the Director of Maintenance on 5/21/24 at 2:00 PM identified that he did not receive the water sampling test results that were collected on 3/21/23. He identified that the facility uses an outside company to assist with the water management plan. He added that he would flush the dead spots as indicated but was unable to locate his documentation. Review of the Facility Water Management plan and policy identified that sampling, management plan, and sampling results should be retained. The Water Management Plan policy further identified that a flushing program would be established wherein the flushing program log provided would be utilized and kept within the water management plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Abbott Terrace Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Abbott Terrace Waterbury, CT 06702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, review of facility documentation, review of facility policy, and interviews, the facility failed to maintain an effective pest control program an failed to ensure the resident environment was free from pests. The findings include: Observation of Resident #58's room on 5/19/24 at 10:15 AM identified mouse sticky traps under the heating system baseboard and behind the resident's dresser for the bed located closest to the window. Interview with Resident #58 on 5/20/24 at 9:45 AM indicated that he/she had seen multiple mice in his/her room. Resident #58 indicated that the previous night there was a mouse observed in the room and he/she needed to move all the belongings off the floor and onto the bed, and even though there was a trap set in the bathroom, mice were still in the room. Observation on 5/19/24 at 10:50 AM in room [ROOM NUMBER] identified small dark fecal droppings on the floor in the corner next to the nightstand located nearest to the window, and a mouse sticky trap set-up under the base board heater. Observation on 5/20/24 at 2:00 PM identified a mouse sticky trap set up on the top of the desk within the 2 East unit nurse's station. Review of the Pest Control binder on 2 East unit nurse's station identified an entry dated 1/2/24 that mice were everywhere on the nursing station, Television room counters, in room [ROOM NUMBER] in trash and dresser. Interview with the Director of Maintenance on 5/21/24 at 12:10 PM identified the facility had been receiving pest control services up until January of 2024 when they stopped due to non-payment of services. Pest control services were restarted as of 5/1/24. During the interim period the Director of Maintenance put out sticky traps to try to trap the mice, during that time approximately 40 mice throughout the facility had been trapped. He further identified the administrator was aware of the continued issue and was aware that pest control services were suspended due to non-payment. Interview with NA #12 on 5/21/24 at 2:30 PM identified that she had seen mice in the rooms and under the dresser and had reported it to the nurse and the maintenance personnel. NA #12 added that mice traps are placed in rooms by the maintenance department but had not seen a professional company on the unit. Interview with NA #11 on 5/21/24 at 2:40 PM identified that mice can be seen everywhere on the unit and have seen mice droppings in resident's bed at times as resident's may have dropped food in the bed while eating. NA #11 added that it has been reported to the maintenance department and nurse, so they are all aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with the Director of Maintenance on 5/21/24 at 3:00 PM in room [ROOM NUMBER] window bed identified small dark fecal droppings on the floor in the corner next to the resident's nightstand, on the top of the resident's nightstand. The drawers of the nightstand was checked and failed to identify any food items nor fecal droppings. The Director of Maintenance identified that he kept a tracking sheet of the rooms or areas that had mice sightings. He added that a mouse sticky trap would be placed in the area and any holes would be filled with mouse foam to prevent the mice from coming inside of the building, which he started a month ago. He further added that there should only be one maintenance book/log at the nurse's station for staff to document and he was unaware of a separate book on the nursing station for pest control. Interview with the pest control contracted service representative on 5/21/24 at 3:14 PM identified pest control services were twice monthly and that back in January 2024 services had been suspended due to non-payment. Pest control was scheduled to come in next Wednesday however were called in earlier by the Director of Maintenance. The plan at this point is to tackle the whole building which is a separate service than what was done bi-monthly previously. The plan was to start with the 4th floor and refill bait traps in the ceilings and in the patient rooms. This service is needed building wide top to bottom for an increased cost. Mice are most active overnight and there is a need to make sure that there are no access to food or else they will go to the food over the bait trap. The bait needs to be refreshed every 6 months building wide but according to the pest control service this has not been done building wide for about two to three years (for an extra cost service), they have been targeting rooms that have complaints of mice and maintenance will notify them which rooms have had sightings of mice. Interview with the Administrator on 5/21/24 at 3:40 PM identified that initially they had talked about bins being purchased for resident food back in January and he found out that 20 bins had been purchased after they were talking about it back in January for the residents to store food in however no further bins could be secured. The receipt from maintenance to show the bins had been purchased, however could not be located. The Administrator identified that due to lack of payment the services had been suspended, however maintenance was putting down traps and he was going to be talking more with the residents about leaving their food out in the upcoming resident council meetings. Observation on 5/22/24 at 2:30 PM with NA #12 and Housekeeper #2 in room [ROOM NUMBER] window bed identified small dark fecal droppings on the floor in the corner next to the resident's nightstand and on the top of the resident's nightstand. Review of the Pest Control Program Description identified the contracted pest control company provides services to [NAME] Health Care Facilities, [NAME] Terrace and noted they will inspect and treat rats, mice, roaches, ants, and silverfish. Frequency of Service: Monthly, per attached schedule. (Updated on 2/6/23). 47402 47900

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47402 Based on facility documentation, and interviews, for three of three Nurses' Aides (NA#7, NA#8, and NA#9) reviewed for required yearly in servicing, the facility failed to complete the minimum of 12 hours of nurse aide training per year. Review of training records for 2022 and 2023 identified Resident Rights, Communication and Behavioral Health training could not be located for NA#7, NA#8, or NA#9. The Communication in-service records could also not be located for 2023. Review of the training schedule for 2023 (none provided for 2022) identified that a Communication in service was on the schedule for January 2023 and Behavioral Health was on the schedule for March 2023. Interview with the Staff Development Nurse (RN #6) on 5/23/24 at 1:54 PM identified she became the staff development nurse in August of 2023 but did not start working onsite at the facility until October of 2023. She identified that she had records of conducting the Abuse training for 2023. RN #6 could not identify where the other trainings were located. RN#6 further identified there was a schedule that was put out to be followed regarding training and that the person in charge of staff development during that time would have been responsible for completing the training. Interview with the Corporate Nurse on 5/23/24 at 2:25 PM identified they were trying to locate the 2022 trainings. Although requested a policy regarding training was not received, however the 2023 schedule of training was received.